CITY OF SCOTTSDALE 2004 COBRA/RETIREE BENEFITS ENROLLMENT FORM

☐ New Enrollment ☐ Change in Enrollment ☐ Dependent Change ☐ Termination of Coverage	Qualifying Event Date _____ Qualifying Event _____	Effective Date:_____
FOR HUMAN RESOURCES USE ONLY ____ Original to Medical File _____ Copy to Payroll on:_____ ____ Copies to Billing File		Received on:

Enrollee Last Name	First Name, MI	Social Security Number
Address		
City	State	Zip
Date of Birth	Home Phone	Work or Cell Phone

MEDICAL

☐ **AETNA OPEN ACCESS EPO** (408)
☐ **MAYO HEALTH TRADITION PPO** (410)
☐ **AETNA OPEN CHOICE PPO** (418)

LEVEL of COVERAGE
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

DENTAL

☐ **ASSURANT DENTAL (HMO)** (425)
Enrollee's Dental Facility ID# _____
☐ **CITY OF SCOTTSDALE SCOTTSMILES PPO DENTAL** (420)
☐ NO DENTAL

LEVEL OF COVERAGE
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

ALTERNATIVE MEDICINE

☐ ALTERNATIVE HEALTHCARE OPTIONS (431)
☐ NO ALTERNATIVE MEDICINE

LEVEL OF COVERAGE
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

ENHANCED VISION

☐ EYEMED VISION CARE (432)
☐ NO ENHANCED VISION

LEVEL OF COVERAGE
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

TWO SIDED FORM – BE SURE TO COMPLETE REVERSE SIDE

CITY OF SCOTTSDALE 2004 COBRA/RETIREE BENEFITS ENROLLMENT FORM

DEPENDENTS (LIST ALL DEPENDENTS TO BE ENROLLED)

Spouse Name (Last, First MI)	Date of Birth	Gender

Spouse is covered on the following plan(s):
☐ Medical ☐ Dental – If Assurant, Dental Office # (if different from employee): _____ ☐ Alternative Medicine ☐ Enhanced Vision

Domestic Partner's Name* (Last, First MI)	Date of Birth	Gender

Domestic Partner is covered on the following plan(s):
☐ Medical

Dependent 1 Name (Last, First MI)	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender

Dependent 1 is covered on the following plan(s):
☐ Medical ☐ Dental – If Assurant, Dental Office # (if different from employee): _____ ☐ Alternative Medicine ☐ Enhanced Vision

Dependent 2 Name (Last, First MI)	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender

Dependent 2 is covered on the following plan(s):
☐ Medical ☐ Dental – If Assurant, Dental Office # (if different from employee): _____ ☐ Alternative Medicine ☐ Enhanced Vision

Dependent 3 Name (Last, First MI)	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender

Dependent 3 is covered on the following plan(s):
☐ Medical ☐ Dental – If Assurant, Dental Office # (if different from employee): _____ ☐ Alternative Medicine ☐ Enhanced Vision

Dependent 4 Name (Last, First MI)	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender

Dependent 4 is covered on the following plan(s):
☐ Medical ☐ Dental – If Assurant, Dental Office # (if different from employee): _____ ☐ Alternative Medicine ☐ Enhanced Vision

Additional dependents may be listed on a separate page.

AUTHORIZATION: By execution of this enrollment form, I understand that I may not change the election during the coming year except in the event of a life change or during open enrollment. By my signature, I certify that the information on this form is true and correct, and that the listed dependents are my legal dependents.

Signature _____ Date _____

HR Signature_____ Date _____

***DOMESTIC PARTNERSHIP COVERAGE**

Only Retirees can cover domestic partners, and only on medical coverage. In addition to all other rules and conditions of city insurance coverage, the following apply to domestic partners coverage: In order for an enrollee to enroll a domestic partner for insurance coverage, both the enrollee and the domestic partner must complete the Domestic Partnership Affidavit. City of Scottsdale Human Resources must approve the affidavit prior to the commencement of coverage. Those with affidavits already on file do not have to resubmit. Enrollees who have domestic partnership insurance coverage are required to complete a Termination of Domestic Partnership form within 30 days of the termination of the domestic partnership. Children of a domestic partner may enroll for coverage only if the domestic partner is enrolled for coverage.

QUALIFIED LIFE STATUS CHANGES

You may not make changes to your benefit plans until the next open enrollment unless you experience a qualified life status change such as the birth of a child, marriage or divorce. If you experience a qualified life status change, you may add or cancel dependents but you may not change plans. You must notify HR within 30 days of a qualifying life status change. It is your responsibility to notify HR when a dependent (spouse/domestic partner or child) is no longer eligible for coverage. Failure to cancel an ineligible dependent from your coverage within 30 days will make you responsible for any claims incurred by an ineligible dependent.